ADDRESS CONFIDENTIALITY PROGRAM APPLICATION

Section 40-15-117 MCA

Please mail completed application to:

ACP
PO Box 201410
Helena, MT 59620-1410

For ACP Use only

ACP #	Filed:

Type of application:

☐ **New** ☐ **Reinstatement** ☐ **Renewal** ☐ **New Name** ☐ _____

APPLICANT'S LEGAL NAME (First, Middle, Last)	**DATE OF BIRTH** *(mm/dd/yyyy)*
Mr. Ms.	

Has applicant ever participated in a confidential address program in Montana or in another state? YES NO

If yes, in what state?

CO-APPLICANT NAMES (First, MI, Last) – Use additional paper if needed	**DATE OF BIRTH** *(mm/dd/yyyy)*	**Relationship to applicant**
A.		
B.		
C.		

APPLICANT MAILING ADDRESS: (address where ACP will send the applicant's mail)

Street Address or PO Box _____ Apt/Suite# ___

City _____ MT ZIP _____ County: _____

RESIDENTIAL ADDRESS (*Participant's actual residential address/physical location is **required** to participate in ACP*)

Street Address: _____ Apt/Suite# ___

City _____ MT ZIP _____ County: _____

DAY TELEPHONE	EVENING TELEPHONE	MESSAGE/OTHER TELEPHONE
( )	( )	( )

BUSINESS NAME AND ADDRESS *(Fill out only if applicant owns a business)*

Business Name: _____ Address: _____

City _____ MT ZIP +4 _____

I am (or the applicant for whom I am the parent/guardian is) a victim of ***sexual assault*** *or* ***domestic violence*** *or* ***stalking****. I am a resident of the State of Montana and have recently relocated to a place unknown to the abuser. I have determined that the Address Confidentiality Program (ACP) should be part of my safety plan. I understand that knowingly providing the ACP with false or incorrect information is punishable under 45-7-202, MCA or other applicable statutes and may jeopardize my participation in the program. To my knowledge, the information contained on this form is true and accurate.*

I hereby designate the Montana Attorney General as my agent for service of process pursuant to 40-15-117, MCA. I understand that moving from the above residential address or changing my mailing address without first notifying the ACP may result in the cancellation of my participation in the ACP.

I (check one) □ *DO* □ *DO NOT want information regarding Voter Registration.*

_____ _____

Signature of Applicant or Parent/Guardian Date

I have worked with this client to develop a safety plan that I believe should include the ACP.

_____ (_____)_____

Victim Advocate (PRINT CLEARLY) City Telephone Number

(Only needs to be completed if applicant has worked with a victim advocate)